Protocols and the *Policy and Procedure Manual*, are required reading for rescue personnel. Each EMT and Paramedic employed by a Sarasota County EMS Provider will have the opportunity to familiarize himself/herself with this material prior to implementation.

An updated version of the *Hazardous Materials Protocols* will be released concurrent with the *Community Protocols*. Although Toxmedics and HazMat Medics will be responsible for the entire contents of these protocols, Emergency Medical Technicians and Paramedics should have a working familiarity with them. There will be no examination questions the *Hazardous Materials Protocols.* All exam questions will be from the *Community Protocols, Handbook and Policy & Procedure Manual* themselves.

Quality EMS requires quality medical direction. The Medical Director writes protocols and policies, investigates complaints and oversees training programs; this is called "off-line medical control". However, for the hour-to-hour clinical control of the system, the Medical Director appoints "on-line medical control" (OLMC) physicians. These are the emergency department (ED) staff physicians of Sarasota, Charlotte and Manatee Counties (Resource Hospitals) and are called "Supervising Physicians". Radio and telephone systems allow communication between rescue crews in the field and their supervising physicians.

Another source of OLMC in Sarasota County is the ability of a medic in the field to contact an on-call Medical Director 24/7 by cellular telephone. The *2017 Policy and Procedure Manual* directs you to call either Dr. Johnson or I on our cell phones. Depending upon the command structure of your respective department, you may need to contact an on-duty administrative officer (EMS Captain, for example). If the officer agrees that direct access is warranted, the Charge Paramedic is authorized to call the on-call Medical Director by cell phone. The Medical Director and Charge Paramedic consult, and a resolution is reached. Should recorded documentation by desired, the Medical Director and crew can meet on Med All (Delta 12), which is recorded and archived by PSCC.

Often, protocols alone are sufficient to guide patient care. When the clinical presentation is complicated or confusing, OLMC serves as a resource to EMS personnel. Orders issued by OLMC take precedence over orders issued by an on-scene healthcare provider. We continue to require that only on-scene physicians may assume OLMC with the permission of the Supervising Physician. On-scene healthcare professionals such as physician assistants, nurses, advanced registered nurse practitioners and respiratory therapists may assist with at the discretion of the Charge Paramedic, but cannot assume medical control.

Licensed midwives attending childbirths at birthing centers or private residences are not healthcare professionals. These individuals may or may not have limited input on-scene at the sole discretion of the Charge Paramedic. If there is a birthing center in your area, make sure you read and understand the policy covering response to

out-of-hospital childbirths attended by midwives. Sarasota County EMS takes a no-nonsense approach to this particular scenario. Respond, assess, stabilize and transport the mother and/or newborn to an appropriate Resource Hospital. Staging at the birthing center and engaging in discussions with the midwife are not authorized. Again, respond, assess, stabilize and transport.

When OLMC is obtained, the physician giving orders becomes responsible for the care of the patient during the prehospital phase of care. It is his/her right to modify the treatment in the protocols *if the best interest of the patient is thereby served.* However, EMS personnel have an obligation to the Medical Director to employ good clinical judgment. They also have an obligation to their employer to follow appropriate guidelines and directives. Therefore, any modification of treatment ordered by a Supervising Physician must be based upon sound medical judgment and must be in accordance with the current standard of practice in prehospital care.

In medicine, "gray areas" are a fact of life. As your Medical Director, I cannot predict all the gray areas you will encounter during the life expectancy of these protocols. Having served as your Medical Director for many years, I have confidence that you are properly trained and approach your work with compassion and common sense.

The *American Heart Association Guidelines for CPR and ECC* is the national standard of care in the United States for EMS organizations. To access the 2015 *Guidelines*, navigate to https://eccguidelines.heart.org. Any ACLS class taught in the last year has been based on the 2015 *Guidelines*. It is not the intention of this *Handbook* to reiterate the information contained in the *Guidelines*.

The issue of consent is an important one. Our birthright as Americans is the right to choose what is (and what is not done) to our bodies by healthcare providers. The law considers healthcare providers to possess medical expertise, and requires them to "inform" patients of proposed medical interventions prior to obtaining permission to carry them out (informed consent). We might not like the decisions our patients make, but we sometimes must be resigned to honor them. As Albert Einstein said, "Two things are infinite: the universe and human stupidity; and I'm not sure about the universe."

However, not every patient encountered by EMS personnel has the legal right to give or withhold consent. Minors and incapacitated adults (intoxication, disease states, head trauma, psychiatric illness) are unable to legally give or withhold consent...they do not have the capacity to do so. In these patients, consent for treatment by EMS personnel is implied.

By the same token, someone may not refuse needed medical attention unless they have capacity to do so. Eighty percent of lawsuits against EMS organizations are brought by patients who were not transported to a hospital. Many patients who refuse needed medical care are high risk. The only way to decide whether or not someone has capacity to refuse care is to assess the patient, paying particular